

BIRTH CERTIFICATE INFORMATION

INSTRUCTIONS

- 1. Complete ALL information on the attached forms to the best of your knowledge.**
- 2. If unmarried, you must obtain the father's signature to add his name to the birth certificate.**
- 3. If unmarried both parents MUST sign the Acknowledgement of Paternity form in the presence of the Birth Certificate Secretary.**

**Hours secretary is available: Monday – Friday
7:30 AM – 4:00 PM.**

If you miss the secretary, you can come to the hospital within 5 days of discharge.

**Phone: 202-8770
or 202-8166**

PREGNANCY HISTORY

<p>Previous live births – do not include this child.</p> <p>37a. now Living _____ Number <input type="checkbox"/> None</p> <p>37b. Now Dead _____ Number <input type="checkbox"/> None</p> <p>37c. Date of Last Live birth _____ (mm/dd/yyyy)</p> <p>Other Pregnancy Outcomes</p> <p>37d. _____ Number <input type="checkbox"/> None</p> <p>37e. Date Last Other Pregnancy Ended _____ (Mm/dd/yyyy)</p>	<p>38. Source of Prenatal Care (check all that apply)</p> <p><input type="checkbox"/> Hospital Clinic <input type="checkbox"/> Public Health Clinic <input type="checkbox"/> Private Physician <input type="checkbox"/> Midwife <input type="checkbox"/> None <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify): _____</p> <hr/> <p>39. Mother's Medicaid Number _____</p>	<p>40. Mother's Pregnancy Weight _____ (pounds)</p> <p>41. Mother's Weight at Delivery _____ (pounds)</p> <p>42. Mother's Height Feet _____ inches _____</p> <p>43. Date Last Normal Menses Began _____ (mm/dd/yyyy)</p> <hr/> <p>PRENATAL CARE</p> <p><input type="checkbox"/> No care</p> <p>44a. Date of First Visit (mm/dd/yyyy) _____</p> <p>44b. Date of Last Visit (mm/dd/yyyy) _____</p> <p>44c. Number of Prenatal Visits _____</p>
<p>45. Cigarette Smoking Before and During Pregnancy. For each time period, enter the number of cigarettes or the number of packs of cigarettes smoked. If NONE, enter 0.</p> <p>Average Number of cigarettes or packs of cigarettes smoked per day.</p> <p>3 months BEFORE pregnancy _____ OR _____</p> <p>FIRST 3 months of pregnancy _____ OR _____</p> <p>SECOND 3 months of pregnancy _____ OR _____</p> <p>THIRD trimester of pregnancy _____ OR _____</p>	<p>46. Principal source of payment for this delivery.</p> <p><input type="checkbox"/> Private Insurance</p> <p><input type="checkbox"/> Medicaid</p> <p><input type="checkbox"/> Self pay</p> <p><input type="checkbox"/> Other (Specify) _____</p>	<p>47. Did mother get WIC food for herself during this pregnancy?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <hr/> <p>48. Mother transferred for maternal medical or fetal indications for this delivery?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, enter the name of the facility mother transferred from.</p>
<p>49. Risk Factors In This Pregnancy (check all that apply)</p> <p>Diabetes</p> <p><input type="checkbox"/> Prepregnancy (diagnosed <u>prior</u> to this pregnancy)</p> <p><input type="checkbox"/> Gestational (diagnosed in this pregnancy)</p> <p>Hypertension</p> <p><input type="checkbox"/> Prepregnancy (chronic)</p> <p><input type="checkbox"/> Gestational (PIH, preeclampsia)</p> <p><input type="checkbox"/> Eclampsia</p> <p><input type="checkbox"/> Previous preterm birth</p> <p><input type="checkbox"/> Other previous poor pregnancy outcome (includes perinatal death, small-for-gestational age/intrauterine growth restricted birth)</p> <p><input type="checkbox"/> Pregnancy resulted from infertility treatment If yes, check all that apply:</p> <p><input type="checkbox"/> Fertility enhancing drugs, Artificial insemination, or intrauterine insemination.</p> <p><input type="checkbox"/> Assisted reproductive technology (e.g. in vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT).</p> <p><input type="checkbox"/> Mother had previous cesarean delivery If yes, how many _____</p> <p><input type="checkbox"/> Antiretrovirals administered during pregnancy or at delivery</p> <p><input type="checkbox"/> None of the above</p>	<p>52. Obstetric Procedures (check all that apply)</p> <p><input type="checkbox"/> Cervical cerclage</p> <p><input type="checkbox"/> Tocolysis</p> <p>External cephalic version:</p> <p><input type="checkbox"/> Successful <input type="checkbox"/> Failed</p> <p><input type="checkbox"/> None of the above</p> <hr/> <p>53. Onset Of Labor (Check all that apply)</p> <p><input type="checkbox"/> Premature rupture of the membranes (prolonged >12 hrs.)</p> <p><input type="checkbox"/> Precipitous labor (<3 hrs)</p> <p><input type="checkbox"/> Prolonged labor (>20 hrs)</p> <p><input type="checkbox"/> None of the above</p> <hr/> <p>54. Characteristics of Labor and Delivery (check all that apply)</p> <p><input type="checkbox"/> Induction of labor</p> <p><input type="checkbox"/> Augmentation of labor</p> <p><input type="checkbox"/> Non-vertex presentation</p> <p><input type="checkbox"/> Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery.</p> <p><input type="checkbox"/> Antibiotics received by the mother during labor.</p> <p><input type="checkbox"/> Chorioamnionitis or maternal temp. 38 C, (100.4 F)</p> <p><input type="checkbox"/> Moderate/heavy meconium staining of the amniotic fluid</p> <p><input type="checkbox"/> Fetal intolerance of labor such that on or more of the following actions was taken: in-utero resuscitation, further assessment, or operative delivery.</p> <p><input type="checkbox"/> Epidural or spinal anesthesia during labor</p> <p><input type="checkbox"/> None of the above.</p>	<p>55. Method of Delivery</p> <p>A. Was delivery with forceps attempted but unsuccessful? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>B. Was delivery with vacuum extraction attempted but unsuccessful? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>C. Fetal presentation at birth</p> <p><input type="checkbox"/> Cephalic</p> <p><input type="checkbox"/> Breech</p> <p><input type="checkbox"/> Other</p> <p>D. Final route and method of delivery (check one)</p> <p><input type="checkbox"/> Vaginal/spontaneous</p> <p><input type="checkbox"/> Vaginal/forceps</p> <p><input type="checkbox"/> Vaginal/vacuum</p> <p><input type="checkbox"/> Cesarean If cesarean was a trial of labor attempted <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>50. Infections Present and/or treated during this pregnancy (check all that apply)</p> <p><input type="checkbox"/> Gonorrhea</p> <p><input type="checkbox"/> Syphilis</p> <p><input type="checkbox"/> Chlamydia</p> <p><input type="checkbox"/> Hepatitis B</p> <p><input type="checkbox"/> Hepatitis C</p> <p><input type="checkbox"/> None of the above</p>	<p>51a. HIV test done prenatally <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>56. Maternal morbidity – complications associated with labor and delivery (check all that apply)</p> <p><input type="checkbox"/> Maternal transfusion</p> <p><input type="checkbox"/> 3rd or 4th degree perineal laceration</p> <p><input type="checkbox"/> Ruptured uterus</p> <p><input type="checkbox"/> Unplanned hysterectomy</p> <p><input type="checkbox"/> Admission to intensive care unit</p> <p><input type="checkbox"/> Unplanned OR procedure following delivery</p> <p><input type="checkbox"/> None of the above.</p>
<p>51b. HIV test done at delivery <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		